

SAMPLE

Vision Plan

Booklet-Certificate

Prepared exclusively for:

Policyholder: Government of Guam

Group policy number: _____

Group policy effective date: October 1, 2020

Plan issue date: October 1, 2021

Welcome

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Some notes on how we use words

- When we say “you” and “your”, we mean both you and any covered dependents.
- When we say “us”, “we”, and “our”, we mean _____.
- Some words appear in **bold** type. We define them in the *Glossary* section.

Sometimes we use technical vision language that is familiar to **vision providers**.

What your plan does – providing covered benefits

Your plan provides **covered benefits**. These are **eligible vision services**. Your plan has an obligation to pay for **eligible vision services**.

How your plan works – starting and stopping coverage

Your coverage under the plan has a start and an end. You start coverage after you complete the eligibility and enrollment process.

Your coverage typically ends when you leave your job. Family members can lose coverage for many reasons, such as growing up and leaving home. To learn more see the *When coverage ends* section.

Ending coverage under the plan doesn’t necessarily mean you lose coverage with us. See the *Special coverage options after your plan coverage ends* section.

How your plan works while you are covered

Your plan provides **covered benefits**. These are **eligible vision services**. Your plan has an obligation to pay for **eligible vision services**.

1. Eligible vision services

So what are **eligible vision services**? They are vision care services that meet these three requirements:

- They appear in the *Eligible vision services under your plan* section.
- They are not listed in the *What your plan doesn't cover –eligible vision service exclusions* section.
- They are not beyond any limits in the schedule of benefits.

2. Providers

You may choose any **vision provider** for the care you need.

3. Paying for eligible vision services– sharing the expense

Generally your plan and you will share the expense of your **eligible vision services** when you meet the general requirements for paying.

How to contact us for help

We are here to answer your questions. You can contact us by:

You can also contact us by:

- Calling _____ Member Services
- Writing us at _____

Who the plan covers

You will find information in this section about:

- Who is eligible
- When you can join the plan
- Who can be on your plan (who can be your dependent)
- Adding new dependents
- Special times you and your dependents can join the plan

Who is eligible

Your **policyholder** decides and tells us who is eligible for vision care coverage.

When you can join the plan

As an employee you can enroll yourself and your dependents:

- At any time
- Once each Plan Year during the annual enrollment period

At other special times during the year (

If you do not enroll yourself and your dependents when you first qualify for vision benefits, you may have to wait until the next annual enrollment period to join.

Who can be on your plan (who can be your dependent)

If your plan includes coverage for dependents, you can enroll the following family members on your plan. (They are your “dependents”.)

- Your legal spouse
- Your domestic partner who meets the rules set by the **policyholder** and requirements under state law
- Your dependent children – your own or those of your spouse or domestic partner
 - Under age 26, as long as they solely depend on your support and they include your:
 - Biological children
 - Stepchildren
 - Legally adopted children, including any children placed with you for adoption
 - Children you are responsible for under a qualified medical support order or court-order (whether or not the child resides with you)

Important note:

You may continue coverage for a disabled child past the age limit shown above.

You can't have coverage as an employee and a dependent and you can't be covered as a dependent of more than one employee on the plan.

Adding new dependents

You can add the following new dependents any time during the year:

- A spouse - If you marry, you can put your spouse on your plan.
 - We must receive your completed enrollment information not more than 31 days after the date of your marriage.
 - Ask your **policyholder** when benefits for your spouse will begin:
 - If we receive your completed enrollment information by the 15th of the month, coverage will be effective no later than the first day of the following month
 - If we received your completed enrollment information between the 16th and the last day of the month, coverage will be effective no later than the first day of the second month
- A domestic partner - If you enter a domestic partnership, you can enroll your domestic partner on your plan. See *Who can be on your plan (Who can be a dependent)* section for more information.
 - We must receive your completed enrollment information not more than 31 days after the date you file a Declaration of Domestic Partnership, or not later than 31 days after you provide documentation required by your **policyholder**.
 - Ask your **policyholder** when benefits for your domestic partner will begin. It will be on the date your Declaration of Domestic Partnership is filed or the first day of the month following the qualifying event date.
- A newborn child or grandchild - Your newborn child or grandchild is covered on your vision plan from the moment of birth and for the first 31 days after birth.
 - To keep your newborn covered, we must receive your completed enrollment information within 60 days of birth.
 - You must still enroll the child within 60 days of birth even when coverage does not require payment of an additional **premium** contribution for the covered dependent.
 - If you miss this deadline, your newborn will not have vision benefits after the first 31 days.
- An adopted child - See *Who can be on your plan (who can be a dependent)* section for more information. An adopted child is covered on your plan for the first 60 days after the adoption is complete or the date the child is placed for adoption. "Placed for adoption" means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child.
 - To keep your adopted child covered, we must receive your completed enrollment information within 60 days after the adoption or the date the child was placed for adoption.
 - If you miss this deadline, your adopted child will not have vision benefits after the first 31 days.
- A foster child - A foster child is covered on your plan for the first 31 days after obtaining legal responsibility as a foster parent. A foster child is a child whose care, comfort, education and upbringing is left to persons other than the natural parents.
 - To keep your foster child covered, we must receive your completed enrollment information within 60 days after the date the child is placed with you.
 - If you miss this deadline, your foster child will not have vision benefits after the first 31 days.
- A step child – You may put a child of your spouse or domestic partner on your plan.
 - You must complete your enrollment information and send it to us within 31 days after the date of your marriage or Declaration of Domestic Partnership with your stepchild's parent.
 - Ask your **policyholder** when benefits for your stepchild will begin. It is the date of your marriage, Declaration of Domestic Partnership or the first day of the month following the qualifying event date.

Inform us of any changes

It is important that you notify us of any changes in your benefit status. This will help us effectively deliver your benefits. Please contact us as soon as possible with changes such as:

- Change of address or phone number
- Change in marital status
- Change of covered dependent status
- A covered dependent who enrolls in any other group vision plan

Special times you and your dependents can join the plan

You can enroll in these situations when:

- You have added a dependent because of marriage, birth, adoption or foster care. See the *Adding new dependents* section for more information.
- You become a citizen, national or lawfully present in the United States.
- You did not enroll in this plan before because:
 - You were covered by another group vision plan, and now that other coverage has ended
 - You had COBRA, and now that coverage has ended
- A court orders you cover a current spouse, domestic partner or a child on your vision plan.

We must receive your completed enrollment information from you within 31 days of the event or the date on which you no longer have the other coverage mentioned above.

Effective date of coverage

Eligible vision services under your plan

Eligible vision services include services provided by an ophthalmologist or optometrist.

You may get vision services and supplies from any **vision providers**. Refer to your schedule of benefits for more information.

You may use **vision providers** of your choice for **eligible vision services** and supplies under this plan.

Vision care services and supplies

Eligible vision services and supplies include those prescribed for the first time and those required because of a change in **prescription**. These include:

- Eyeglass frames, **prescription** lenses or **prescription** contact lenses that are identified by a **vision provider**

What your plan doesn't cover –eligible vision service exclusions

In this section we tell you about the exclusions that apply to your plan.

Exclusions

The following are not **eligible vision services** under your plan except as described in the *Eligible vision services under your plan* section of this booklet-certificate, or by a rider or amendment included with this certificate:

Cornea transplants

- Cornea (corneal graft with amniotic membrane)

Cosmetic services and plastic surgery

- Any treatment, surgery (**cosmetic** or plastic), service or supply to alter, improve or enhance the shape or appearance of the body. Whether or not for psychological or emotional reasons.

Court-ordered services and supplies

- Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding

Examinations

Any vision examinations needed:

- During your stay in a hospital or other facility for medical care
- For the purpose of the fitting of contact lenses
- Because a third party requires the exam. Examples are, examinations to get or keep a job, or examinations required under a labor agreement or other contract
- Because a law requires it
- To buy insurance or to get or keep a license
- To travel
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity

Laser in-situ keratomileusis (LASIK)

- Including related procedures designed to surgically correct refractive errors

Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision)

Other primary payer

- Payment for a portion of the charge that Medicare or another party is responsible for as the primary payer

Personal care, comfort or convenience items

- Any service or supply primarily for your convenience and personal comfort or that of a third party

Services provided by a family member

- Services provided by a spouse, domestic partner, parent, child, step-child, brother, sister, in-law or any household member

Treatment in a federal, state, or governmental entity

- Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws

Vision care services and supplies

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing
- Aniseikonic lenses
- Medical and/or surgical treatment of the eye, eyes, or supporting structures
- Any vision examination, or any corrective eyewear required by a **policyholder** as a condition of employment, and safety eyewear
- Services provided as a result of any workers' compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof
- Plano (non-prescription) lenses
- Non-prescription sunglasses
- Services rendered after the date a member ceases to be covered under the policy, except when vision materials ordered before coverage ended are delivered, and the services rendered to the insured member are within 31 days from the date of such order
- Services or materials provided by any other group benefit plan providing vision care

Who provides the care

Just as the starting point for coverage under your plan is whether the services and supplies are **eligible vision services**. This section tells you about **vision providers**.

Vision providers

When you need vision supplies, you can go to any **vision provider** to provide **eligible vision services** and supplies to you.

You may have to pay for services at the time that they are provided. You may be required to pay the full charges and submit a claim for reimbursement to us. You are responsible for completing and submitting claim forms for reimbursement of **eligible vision services** that you paid directly to a **vision provider**.

We will tell you what we have paid for **eligible vision services** and supplies. It will tell you if you owe any amounts or if any services or supplies are not covered. You can receive this from us by e-mail or through the mail.

What the plan pays and what you pay

Who pays for your **eligible vision services** – this plan, both of us, or just you? That depends. This section gives the general rule and explains your vision supply maximums listed in your schedule of benefits

We also remind you that sometimes you will be responsible for paying the entire bill – for example, if you get care that is not an **eligible vision service**.

Special financial responsibility

You are responsible for the entire expense of cancelled or missed appointments

Neither you nor we are responsible for:

- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage
- Charges, expenses, or costs in excess of any maximum

Where your schedule of benefits fits in

How your vision supply maximum works

The maximum is the most your plan will pay for **eligible vision services** incurred by a covered person per 12 consecutive month period. You are responsible for any amounts above the maximum.

Important note:

See the schedule of benefits for maximums that apply.

When you disagree - claim decisions and appeals procedures

In the previous section, we explained how you and we share responsibility for paying for your **eligible vision services**.

When a claim comes in, we review it, make a decision and tell you how you and we will split the expense. We also explain what you can do if you think we got it wrong.

Claim procedures

You or your **vision provider** are required to send us a claim in writing. You can request a claim form from us. We will review that claim for payment to the **vision provider** or to you as appropriate.

Notice	Requirement	Deadline
Submit a claim	<ul style="list-style-type: none">You should notify and request a claim form from us.The claim form will provide instructions on how to complete and where to send the form(s)	<ul style="list-style-type: none">You must send us notice and proof as soon as reasonably possible.If you are unable to complete a claim form, you may send us:<ul style="list-style-type: none">A description of servicesBill of chargesAny vision documentation you received from your vision provider
Proof of claim When you have received a service from an eligible vision provider , you will be charged. The information you receive for that service is your proof of loss.	<ul style="list-style-type: none">A completed claim form and any additional information required by us.	<ul style="list-style-type: none">You must send us notice and proof as soon as reasonably possible
Benefit payment	<ul style="list-style-type: none">Written proof must be provided for all benefitsIf any portion of a claim is contested by us, the uncontested portion of the claim will be paid promptly after the receipt of proof of loss.	<ul style="list-style-type: none">Benefits will be paid as soon as the necessary proof to support the claim is received.

Communicating our claim decisions

The amount of time that we have to tell you about our decision on a claim is shown below.

Post-service claim

A post service claim is a claim that involves vision care services you have already received.

Adverse benefit determinations

The difference between a complaint and an appeal

A complaint

An appeal

Appeals of adverse benefit determinations

You can appeal our adverse benefit determination. We will assign your appeal to someone who was not involved in making the original decision. You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination. Or you can call Member Services. You need to include:

- Your name
- The **policyholder's** name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like us to consider

Another person may submit an appeal for you, including a **vision provider**. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your **vision provider**). You should fill out an authorized representative form telling us that you are allowing someone to appeal for you. You can get this form by contacting us. You can use an authorized representative at any level of appeal.

You can appeal two times under this plan. If you appeal a second time you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

Timeframes for deciding appeals

Exhaustion of appeals process

-

Recordkeeping

Fees and expenses

We do not pay any fees or expenses incurred by you when you submit a complaint or appeal.

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When coverage ends

Coverage can end for a number of reasons. This section tells you how and why coverage ends. And when you may still be able to continue coverage.

When will your coverage end?

Your coverage under this plan will end if:

- This plan is discontinued
- The **group policy** ends
- You voluntarily stop your coverage
- You are no longer eligible for coverage
- Your employment ends
- You do not make any required **premium** payment
- We end your coverage
- You become covered under another vision plan offered by your **policyholder**

When coverage may continue under the plan

Your coverage under this plan will continue if:

Your employment ends because of illness, injury, sabbatical or other authorized leave as agreed to by the policyholder and us.	<p>If premium payments are made for you, you may be able to continue to coverage under the plan as long as the policyholder and we agree to do so and as described below:</p> <ul style="list-style-type: none"> Your coverage may continue, until stopped by the policyholder, but not beyond 30 months from the start of your absence.
Your employment ends because of a temporary lay-off, temporary leave of absence, sabbatical, or other authorized leave as agreed to by the policyholder and us.	<p>If premium payments are made for you, you may be able to continue to coverage under the plan as long as the policyholder and we agree to do so and as described below:</p> <ul style="list-style-type: none"> Your coverage will not continue after the month in which your absence started.
<p>Your employment ends because:</p> <ul style="list-style-type: none"> Your job has been eliminated You have been placed on severance, or This plan allows former employees to continue their coverage. 	You may be able to continue coverage. See the <i>Special coverage options after your plan coverage ends</i> section.
Your employment ends because of a paid or unpaid medical leave of absence	<p>If premium payments are made for you, you may be able to continue coverage under the plan as long as your policyholder and we agree to do so and as described below:</p> <ul style="list-style-type: none"> Your coverage may continue until stopped by your policyholder but not beyond 30 months from the start of the absence.
Your employment ends because of a leave of absence that is not a medical leave of absence	<p>If premium payments are made for you, you may be able to continue coverage under the plan as long as your policyholder and we agree to do so and as described below:</p> <ul style="list-style-type: none"> Your coverage will not continue after the month in which your absence started.
Your employment ends because of a military leave of absence.	<p>If premium payments are made for you, you may be able to continue to coverage under the plan as long as the policyholder and we agree to do so and as described below:</p> <ul style="list-style-type: none"> Your coverage may continue until stopped by the policyholder but not beyond 18 months from the start of the absence.

When will coverage end for any dependents?

Coverage for your dependent will end if:

- Your dependent is no longer eligible for coverage.
- The **group policy** ends
- You do not make the required **premium** contribution toward the cost of dependents' coverage.

- Your coverage ends for any of the reasons listed above

In addition, coverage for your domestic partner will end on the earlier of:

- The date this plan no longer allows coverage for domestic partners.
- The date the domestic partnership ends.

death. See the *Special coverage options after your plan coverage ends* section for more information.

Why would we end you and your dependents coverage?

We will give you 31 days advance written notice before we end your coverage because you commit fraud or intentionally misrepresent yourself when you applied for or obtained coverage. You can refer to the *General provisions – other things you should know* section for more information on rescissions.

On the date your coverage ends, we will refund to the **policyholder** any prepayments for periods after the date your coverage ended.

Special coverage options after your plan coverage ends

This section explains options you may have after your coverage ends under this plan. Your individual situation will determine what options you will have.

How can you extend coverage for vision care services and supplies when coverage ends?

If your coverage ends while you are not totally disabled, your plan will cover vision services and supplies for eyeglasses and contact lenses within 30 days after your coverage ends if:

- A complete vision exam was performed in the 30 days before your coverage ended, and the exam included refraction.
- The exam resulted in contact or frame lenses being prescribed for the first time, or new contact or frame lenses ordered due to a change in **prescription**.

How can you extend coverage for your disabled child beyond the plan age limits?

You have the right to extend coverage for your dependent child beyond the plan age limits. If your disabled child:

- Is not able to be self-supporting because of mental or physical disability and
- Depends mainly (more than 50% of income) on you for support.

The right to coverage will continue only as long as a **physician** certifies that your child still is disabled.

We may ask you to send us proof of the disability within 90 days of the date coverage would have ended. Before we extend coverage, we may ask that your child get a physical exam. We will pay for that exam.

We may ask you to send proof that your child is disabled after coverage is extended. We won't ask for this proof more than once a year. You must send it to us within 31 days of our request. If you don't, we can terminate coverage for your dependent child.

General provisions – other things you should know

Administrative provisions

How you and we will interpret this booklet-certificate

How we administer this plan

We apply policies and procedures we've developed to administer this plan.

Who's responsible to you

We are responsible to you for what our employees and other agents do.

We are not responsible for what is done by your **vision providers**. They are not our employees or agents.

Coverage and services

Your coverage can change

Your coverage is defined by the **group policy**. This document may have amendments or riders too. Under certain circumstances, we or your **policyholder** or the law may change your plan. Only we may waive a requirement of your plan. No other person – including your **policyholder** or **vision provider** – can do this.

If a service cannot be provided to you

Sometimes things happen that are outside of our control. These are things such as natural disasters, epidemics, fire and riots.

We will try hard to get you access to the services you need even if these things happen. But if we can't, we may refund you or your **policyholder** any unearned **premium**.

Legal action

Records of expenses

You should keep complete records of your expenses. They may be needed for a claim.

Things that would be important to keep are:

- Names of **physicians** and **vision providers** who provide services
- Dates expenses are incurred
- Copies of all bills and receipts

Honest mistakes and intentional deception

Honest mistakes

You or your **policyholder** may make an honest mistake when you share facts with us. When we learn of the mistake, we may make a fair change in **premium** contribution or in your coverage. If we do, we will tell you what the mistake was. We won't make a change if the mistake happened more than 2 years before we learned of it.

Intentional deception

If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious effects on your coverage. These include, but are not limited to:

- Loss of coverage, starting at some time in the past.
- Loss of coverage going forward.
- Denial of benefits.
- Recovery of amounts we already paid.

We also may report fraud to criminal authorities.

Rescission means you lose coverage both going forward and going backward. If we paid claims for your past coverage, we will want the money back.

You have special rights if we rescind your coverage.

- We will give you 30 days advanced written notice of any rescission of coverage.
- You have the right to an _____ appeal.

Some other money issues

Assignment of benefits

When you see a **vision provider** they will usually bill us directly. We may choose to pay you or to pay the **vision provider** directly.

Recovery of overpayments

Premium contribution

This plan requires the **policyholder** to make **premium** contribution payments. If payments are made through a payroll deduction with the **policyholder**, the **policyholder** will forward your payment to us. We will not pay benefits under this booklet-certificate if **premium** contribution payments are not made. Any benefit payment denial is subject to our appeals procedure. See the *When you disagree - claim decisions and appeals procedures* section.

Payment of premiums

The first **premium** payment for this policy is due on or before your **effective date of coverage**. Your next **premium** payment will be due the 1st of each month ("**premium** due date"). Each **premium** payment is to be paid to us on or before the **premium** due date.

Your vision information

We will protect your vision information. We use and share it to help us process your claims and manage your policy. You can get a free copy of our Notice of Privacy Practices. Just call Member Services. When you accept coverage under this policy, you agree to let your **vision providers** share your information with us. We will need information about your physical and mental condition and care.

Glossary

_____ **Insurance Company**, an affiliate, or a third party vendor under contract with _____.

Calendar Year

A period of 12 months that begins on January 1st and ends on December 31st.

Cosmetic

Services, drugs or supplies that are primarily intended to alter, improve or enhance your appearance.

Covered benefits

Eligible vision services that meet the requirements for coverage under the terms of this plan.

Effective date of coverage

The date you and your dependent's coverage begin under this booklet-certificate as noted in our records.

Eligible vision services

The vision care services and supplies listed in the *Eligible vision services under your plan* section and not listed or limited in the *What your plan doesn't cover –eligible vision service exclusions* section or in the schedule of benefits.

Group policy

The **group policy** consists of several documents taken together. These documents are:

- The group application
- The **group policy**
- The booklet-certificate(s)
- The schedule of benefits
- Any amendments to the **group policy**, the booklet-certificate, and the schedule of benefits

Physician

A skilled health care professional trained and licensed to practice medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy.

Policyholder

An employer or organization who agrees to remit the **premiums** for coverage under the **group policy** payable to _____.

Premium

The amount you or your **policyholder** are required to pay to _____ for your coverage.

Prescription

A written order for the dispensing of **prescription** lenses or **prescription** contact lenses by an ophthalmologist or optometrist.

Vision provider

Any individual legally licensed to provide vision services or supplies.

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Additional Information Provided by

Government of Guam

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to \$ 110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights you should contact:

Confidentiality Notice

_____ considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number or visit our Internet site at _____.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between _____ and your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

If Health Expense Benefits has reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If the group contract provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when _____ gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.